Division of Health Care Financing HCF 11096 (Rev. 03/06)

WISCONSIN MEDICAID PRIOR AUTHORIZATION / HOME CARE ATTACHMENT (PA/HCA)

Instructions: Print or type clearly. Refer to the Prior Authorization/Home Care Attachment (PA/HCA) Completion Instructions, HCF 11096A, for information on completing this form.

1. Prior Authorization Number 2a. Name and Telephone Number Recipient 2b. Recipient Medicaid Identification Number 3. Start of Care Date	mormation on completing								
3. Start of Care Date A. Certification Period From To	SECTION I — RECIPIE	NT INFO						,	
SECTION III — BRIEF MEDICAL AND SOCIAL INFORMATION 7. Durable Medical Equipment 8a. Functional Limitations 1 Amputation 5 Paralysis 9 Legally Blind (Incontinence) 7 Ambulation 11 Other (Incontinence) 8 Section 12 Other (Specify in Element 8) Specify other activities permitted. 9 Section III — BRIEF MEDICAL AND SOCIAL INFORMATION 7. Durable Medical Equipment 8a. Functional Limitations 2 Section III — Brief Medical Equipment 8b. If "Other" checked in Element 8a, specify other functional limitations. Contracture 7 Ambulation 11 Other (Specify in Element 8b) 9 Section III — Brief Medical Equipment 8 Section III — Brief Medical Equipment 9 Section III — Brief Medical Equipment 8 Section III — Contracture 7 Ambulation 11 Other (Specify in Element 8b) 9 Section III — Brief Medical III —	Prior Authorization N	umber	2a. Name a	and ⁻	Гele	phone Number -	— Recipient	2b.	Recipient Medicaid Identification Number
SECTION III — PERTINENT DIAGNOSES AND PROBLEMS TO BE TREATED 5. Principal Diagnosis (ICD-9-CM Code, Description, Date of Diagnosis) 6. Surgical Procedure and Other Pertinent Diagnoses (ICD-9-CM Code Description, Date of Procedure or Diagnoses) 8a. Functional Limitations 7. Durable Medical Equipment 8a. Functional Limitations 9. Legally Blind 1. Amputation 5. Paralysis 9. Legally Blind 1. Amputation 5. Paralysis 9. Legally Blind 2. Bowel / Bladder (Incontinence) 7. Ambulation 11. Other (Speedly in Element 6b) 9a. Activities Permitted 9a. Activities Permitted 1. Complete Bedrest 6. Partial Weight Bearing 10. Whoelchair 2. Bedrest BRP 7. Independent at Home 11. Walker 3. Up As Tolerated 8. Crutches 12. No Restrictions 13. Other (Speedly in Element 8b) 1. Other (Speedly in Element 9b) 1. Other (Speedly in Element 9c)	3. Start of Care Date						4. Certification Period		
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	5 🗖 Exercises Prescribed					⊨iement 9b)			
10. Medications (Dose / Frequency / Route)	10. Medications (Dose /	Frequer	ncy / Route)				I		
	11. Allergies								
11. Allergies									
11. Allergies									

Prior Authorization	Number				
12. Nutritional Requ	uirements				
13. Mental Status	1 Oriented	3 G Forgetful	5 Disoriented	7 Agitated	
	2 Comatose	4 Depressed	6 Lethargic	8	
14. Prognosis	1 🗖 Poor	2 Guarded	3 🗖 Fair	4 Good 5 Excellent	
SECTION IV — OR	DERS				

^{15.} Orders for Services and Treatments (Number / Frequency / Duration)

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Prior Authorization Number		
16. Goals / Rehabilitation Potential / Disc	charge Plans	
SECTION V — SUPPLEMENTARY MEI	DICAL INFORMATION	
17. Date Physician Last Saw Recipient	18. Dates of Last Inpatient Stay Within 12 Months (If Known)	19. Type of Facility for Last Inpatient Stay (If Applicable)
	Admission Discharge	(II Applicable)
20. Current Information (Summary from	Each Discipline / Treatments / Clinical Facts)	1
21. Home or Social Environment		
21. Home of Social Environment		
22. Medical and / or Nonmedical Reason	s Recipient Regularly Leaves Home (Include Frequency)	

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ers Requesting Private	Duty Nursing Services / Optional for
on this form is complete le for ensuring that this	e and accurate and I am familiar with all PA/HCA is carried out as specified.
	25. Date Signed — Authorized Nurse Completing Form
e Received Physician-S	Signed Form
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As the nurse countersigning this PA/HCA, I confirm the following: All information entered on this form is complete and accurate and I am familiar with all of the information entered on this form. When I am providing services, I am responsible for ensuring that this PA/HCA is carried out as specified.

31. **COUNTERSIGNATURE** — Nurse in Independent Practice (Only if Sharing Case)

32. Date Countersigned — Nurse in Independent Practice

Anyone who misrepresents, falsifies, or conceals essential information required for payment of state and/or federal funds may be subject to fine, imprisonment, or civil penalty under applicable state and/or federal laws.